Health Homes Program

Spotlight on Member Success Stories

Department of Health Care Services | February 2021

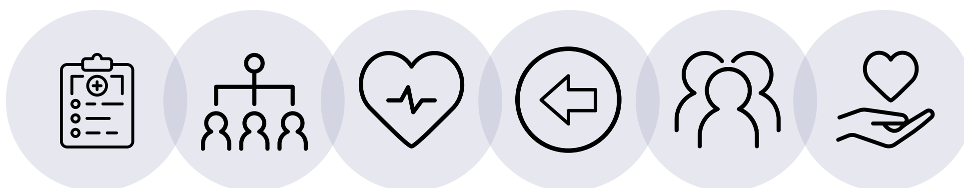
Health Homes Program Success Stories

The Medi-Cal Health Homes Program (HHP) helps manage and coordinate care for Medi-Cal managed care plan (MCP) members with certain chronic health and/or mental health conditions who have high health care needs or who are experiencing chronic homelessness. The HHP is administered by 17 MCPs and a network of health care and social service providers (Community-Based Care Management Entities, or CB-CMEs) across 12 counties.

The HHP provides the following six core services for Medi-Cal beneficiaries: 1) comprehensive care management, 2) care coordination, 3) health promotion, 4) comprehensive transitional care, 5) individual and family support services, and 6) referral to community and social supports. Providing access to these services is even more important today in the context of the COVID-19 Public Health Emergency and the potential secondary health impacts resulting from delays and disruptions in care and increased stress.

The HHP was launched in three phases, starting with San Francisco County on July 1, 2018, and most recently Orange County on January 1, 2019. As of July 1 2020, all 12 counties and phases of the HHP have been successfully implemented. Since implementation began, HHP service providers have enrolled and supported thousands of members. For more information about the HHP, please visit bit.ly/HealthHomes.

These member success stories spotlight examples of how MCP and CB-CME care teams are supporting and improving the lives of HHP enrollees every day.



Supporting Members During the COVID-19 Public Health Emergency

A member stated that they had not seen their primary care provider (PCP) in over six months and that they were afraid to go out due to the COVID-19 public health emergency. The member also said they wanted an update on their condition from their PCP. The HHP care coordinator worked with the member to complete their Health Action Plan (HAP) and contacted their PCP office to ask if the office could call the member and possibly schedule an appointment.

During the HHP care coordinator's weekly call with the member, the member stated that the PCP came to their home and addressed all of their medical concerns. The member also said that they now have a nurse check on them twice per week and their PCP will visit them every month until the COVID-19 public health emergency ends. The member stated that they feel much better now that they have seen their doctor and is getting the support they need.

Coordinating Care to Improve Health

An HHP member's lab results have demonstrated significant improvement since they enrolled in the Health Homes Program. Their doctor noted that the lab results are "the best they've been since they came to see us." This success is attributed to a variety of interventions initiated by the member's Community-Based Care Management Entity.

The member's care coordinator works with the member's family to encourage participation in regularly scheduled appointments and communicates with their primary care provider (PCP) and specialists to ensure continuity of care. The care coordinator has given the member informational resources to help educate them about their diagnoses – including websites, handouts and YouTube videos. These resources covered nutrition and other lifestyle factors that could influence the member's health. The care coordinator has continued providing support during the COVID-19 public health emergency by offering telehealth services. It was during this time that their labs started showing significant improvement.

The member is encouraged and excited about the progress they have made so far. The member's health care providers report that they are much more engaged in regularly scheduled doctor and specialist visits since enrolling in the Health Homes Program.

Supporting Members Experiencing Homelessness

An HHP care team is helping a member who has had many challenges, including chronic medical conditions, addiction, and homelessness. They were in and out of the emergency room and also had a major surgery.

At a local homeless shelter, the member met an HHP care coordinator who helped them enroll in the HHP and complete their Health Action Plan (HAP). While residing at the shelter, with the assistance of the shelter case manager and the HHP care coordinator, the member was able to receive low-income housing. The care coordinator helped them furnish the entire apartment. Additionally, the member ended up helping the elderly in their community by shopping and cleaning their homes. The income that the member made helped them buy their first car. The member said they achieved goals that they never thought were possible.

The member stays in contact with the team on a regular basis and is forever grateful to the HHP Care Coordinator for helping. They feel that they were given a second chance in life with the resources and guidance from the care coordinator, and have achieved goals that they never thought were possible.

Supporting Members Experiencing Homelessness

A member experiencing many chronic health conditions and homelessness enrolled in the HHP after a long inpatient hospital stay. They and the HHP care coordinator worked together to develop a tailored Health Action Plan (HAP) to set goals. The care coordinator accompanied the member to their primary care provider (PCP) and community provider appointments, called the member to remind them about their appointments, and connect them to mental health resources.

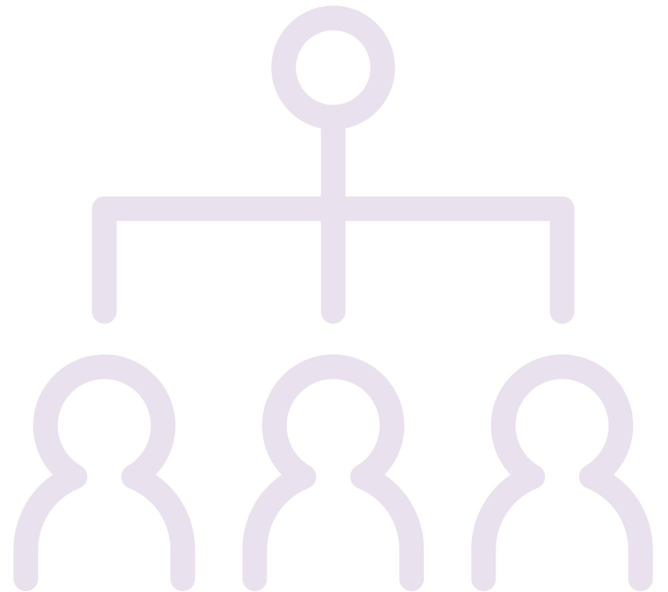
Then, the member received a housing opportunity! The care coordinator helped with housing transition preparation (e.g. organizing a move date and day of transportation) and post-move transition assistance (e.g. ensuring materials for basic needs were available for the member and attended the housing orientation with the member). After the transition, the member and their care coordinator shifted their goals to work on connecting the member to dental services, improving communication with providers, building their social support network, and obtaining Social Security Income.

In addition to the HHP care coordinator, the Senior Medical Director, peer care coordinators, nurses, and pharmacists all shared their best practices and advice during case conferences to help assist with the transition of the member, with complex health care needs from medical respite to independent housing. As of now, the member has successfully graduated out of the Health Homes Program!

Health Promotion and Education

A team member on the HHP member's care team identified a concern during their second assessment that was due to previous medical complications. The member reported memory problems in filling out paperwork, and that their conversations tend to wander off subject leading to them feeling "insecure about going out." Additionally, the member became anxious and depressed at times. In the past, their primary care provider (PCP) recommended that they join a support group for socialization, and to maintain cognitive wellness.

When they first enrolled in the Health Homes Program, they shared that they had been unable to call the support group the member's PCP recommended. The care coordinator expressed understanding of the challenges with calling but continued to encourage the member to reach out for support. The member stated they would call that same day.



During the latest HHP meeting, the care coordinator was happy to learn that the member had successfully attended a support group. They reported having a positive experience connecting to people with the same condition and that they would like to continue engaging in this type of support activity once COVID-19 in-person guidelines have been lifted. The care coordinator will continue to engage with the member for completion of their other Health Action Plan (HAP) goals.

HHP Member

An HHP member's comment about having a care coordinator:

"Got things done that I had been trying to do by myself for over a year in, like, weeks."

The member now has supports in place through a local non-profit and is receiving assistance with applying for SSI and services for Rapid Rehousing.

HHP Staff

I helped a member who has experienced difficulties related to multiple medical issues. I am helping the member receive their medications through their pharmacy and making sure that they have refills on file. The member worked through their medication problem by communicating with me every time they had an issue with a refill or a certain dosage. I am always quick to relay the messages to the providers or pharmacists.

"This member now has trust in me and communicates with me when a problem arises."

DHCS
California Department of
Health Care Services